

**WASHINGTON STATE
REPORTING REQUIREMENTS**

AIDS and HIV infection are reportable to local health authorities in Washington in accordance with WAC 246-101. HIV/AIDS cases are reportable within 3 working days and reporting does not require patient consent.

**ASSURANCES OF CONFIDENTIALITY
AND EXCHANGE OF MEDICAL INFORMATION**

- Several Washington State laws pertain to HIV/AIDS reporting. They include: Maintaining individual case reports for AIDS and HIV as confidential records (WAC 246-101-120,520,635); protecting patient identifying information, destroying identifying information on asymptomatic HIV-infected individuals after 90 days (WAC 246-101-230, 520, 635); investigating potential breaches of confidentiality of HIV/AIDS identifying information (WAC 246-101-520) and not disclosing HIV/AIDS identifying information (WAC , 246-101-120, 230, 520, 635 and RCW 70.24.105).
- Health care providers and employees of a health care facilities or medical laboratories may exchange HIV/AIDS information in order to provide health care services to the patient and release identifying information to public health staff responsible for protecting the public through control of disease (WAC-101-120, 230 and 515; and RCW 70.24.105).
- Anyone who violates Washington State confidentiality laws may be fined a maximum of \$10,000 or actual damages; whichever is greater (RCW 70.24.080-084).
- HIPAA regulations permit covered entities to disclose protected health information to a public health authority, without patient consent. 45 CFR 164.512 (a)(1)(b) permits it if the disclosure of the specific information is required by law (statute or administrative rule). 45 CFR 164.512(b)(1)(i) permits disclosure of the specific information if the public health authority is "...authorized by law to collect or receive such information for the purpose of preventing or controlling disease...."

Return completed form to:



HIV/AIDS Epidemiology Program
400 Yesler Way, 3rd Floor
Seattle, WA 98104
(206)296-4645

FOR PARTNER NOTIFICATION INFORMATION

- Washington state law requires health care providers to offer partner notification assistance to persons with HIV infection (WAC 246-100-209) and establishes rules for providing such assistance (WAC 246-100-072).
- For assistance in notifying spouses, sex partners or needle-sharing partners of persons with HIV/AIDS, please call Claudia Catastini, HIV/AIDS Prevention & Education Services, DOH, at (360) 236-3422, or your local health department. In King County, please call Edith Allen, Public Health Seattle & King County, at (206) 731-4377.

REFERENCES FROM THE OTHER SIDE

- ¹Patient identifier information is not sent to CDC.
- ²Outpatient dx: ambulatory diagnosis in a physician's office, clinic, group practice, etc.
Inpatient dx: diagnosed during a hospital admission of at least one night.
- ³After 1977 and preceding the first positive HIV antibody test or AIDS diagnosis.
- ⁴If case progresses to AIDS, please notify health department.
- ⁵If further clarification of definitive and presumptive diagnostic methods is needed, please contact health department.
- ⁶Chronic: more than one month's duration.
- ⁷Recurrent: 2 or more episodes within a 1-year period.
- ⁸Wasting syndrome due to HIV infection includes >10% weight loss plus 1) chronic diarrhea and/or 2) fever and chronic weakness lasting over 30 days in absence of a concurrent illness other than HIV which could explain the findings (e.g., cancer, TB, cryptosporidiosis, or other specific enteritis).

FOR HEALTH DEPARTMENT USE ONLY

ID Code		
FUI Assigned:		
<input type="checkbox"/> Complete	<input type="checkbox"/> Incomplete	<input type="checkbox"/> OOS
RVCT Number:		
LCD:		
Spousal Notification Follow-up: <input type="checkbox"/> Letter to PMD		
PN:		
Child's Soundex :	Child's State Patient No.	

Comment :

Patient Name¹ (Last, First, Middle):

AKA (Nickname, Previous Last Names, etc.):

Phone #:

Social Security #:

Current Street Address:

City:

Zip Code:

[1] Alive
[2] Dead

Birthdate (mm/dd/yyyy)

Death Date (mm/dd/yyyy)

State of Death:

Sex at Birth:
[1] Male
[2] Female

Current Gender:
[1] Male [3] Male to Female
[2] Female [4] Female to Male
[5] Other

Ethnicity:
[1] Hispanic
[2] Not Hispanic

Race (check all that apply):
☐ White
☐ Black
☐ Asian
☐ Hawaiian/Pacific Islander
☐ Amer. Indian/Alaska Native

Marital Status:
☐ Married
☐ Divorced
☐ Widowed
☐ Never married
☐ Unknown

Country of Birth: ☐ U.S. ☐ Other:

Was patient dx in another state? [1] Yes [2] No
If yes, specify state:

Residence at time of diagnosis if different than current address:
City: County: Zip Code:

Med. Record #/Patient Code:

Name & City of facility of diagnosis:

[1] Outpatient dx² [2] Inpatient dx²

Physician: Phone: City:

Person reporting if other than physician: Phone:

PATIENT HISTORY SINCE 1977³

Check all that apply

Yes

No

Unk

Sex with male.....

☐

☐

☐

Sex with female.....

☐

☐

☐

Injection drug use.....

☐

☐

☐

Received clotting factors for hemophilia.....

☐

☐

☐

Transfusion.....

☐

☐

☐

Organ transplant/Artificial insemination.....

☐

☐

☐

Heterosexual relations with:

Injection drug user.....

☐

☐

☐

Bisexual man.....

☐

☐

☐

Person with hemophilia.....

☐

☐

☐

PWA/HIV transfusion recipient.....

☐

☐

☐

PWA/HIV transplant recipient.....

☐

☐

☐

PWA/HIV, risk not specified.....

☐

☐

☐

Worked in health-care or laboratory setting..

☐

☐

☐

If yes, occupation:

CONFIDENTIAL HIV/AIDS
ADULT CASE REPORT

LABORATORY DATA⁴

Test Date (mo/yr)

Last documented negative test ____/____ Type of test:

EARLIEST POSITIVE HIV ANTIBODY TESTS:

Type of Test:

Test Date (mo/yr)

HIV-1 EIA ____/____ ☐ Test not done

HIV-1 Western Blot or IFA ____/____ ☐ Test not done

HIV VIRAL LOAD TESTS:

Type of Test:

Test Date (mo/yr)

Earliest HIV Viral Load ____/____ ☐ Copies per mL ____ ☐ Undetectable

Most recent HIV Viral Load ____/____ ☐ Copies per mL ____ ☐ Undetectable

OTHER HIV TESTS

Type of test: Rapid, Antigen, Culture, HIV-2, LS-EIA, ____

Date (mo/yr): ____/____ Result:

PHYSICIAN DIAGNOSIS OF INFECTION:

No laboratory tests are available but Physician documents HIV infection Date (mo/yr): ____/____

CD4 LEVELS

Type of Test:

Test Date (mo/yr)

Count

Percent

Earliest CD4 ____/____ ____ cells/µl ____%

Most Recent CD4 ____/____ ____ cells/µl ____%

First CD4 <200 µl or < 14% ____/____ ____ cells/µl ____%

TREATMENT / SERVICES REFERRALS

Yes

No

Unk

NA

Has this patient been informed of his/her HIV infection? ☐ ☐ ☐

This patient is receiving or has been referred for:

HIV related medical service

☐

☐

☐

HIV Social Service Case Management

☐

☐

☐

Substance abuse treatment services

☐

☐

☐

☐

This patient received or is receiving:

Anti-retroviral therapy

☐

☐

☐

PCP prophylaxis

☐

☐

☐

Partner notification per WAC 246-100-072 for cases diagnosed after 9/1/99. Some local health departments (including King and Pierce) will uniformly provide patient counseling and referral services for all patients.

☐ Check this box to receive a phone call from the health department for assistance in patient counseling and referral services.☐ Check this box to certify that the health care provider and patient assume full responsibility for ensuring known spouses, sex partners, and needle-sharing partners will be notified of exposure to HIV.

HEALTH DEPARTMENT USE ONLY

☐ HIV ☐ AIDS Stateno: _____

Date: ____/____/____ Source: _____

☐ New Case ☐ Progression ☐ Update, no status change

CLINICAL AIDS

☐ CHECK HERE IF PATIENT HAS NO AIDS INDICATOR DISEASES dx method⁶

If checked, skip Clinical AIDS section.

Disease

Dx Date (mo/yr)

Presumptive

Definitive

Candidiasis, bronchi, trachea, or lungs ____/____ ☐ ☐

Candidiasis, esophageal ____/____ ☐ ☐

Cervical cancer, invasive ____/____ ☐

Coccidioidomycosis, disseminated or extrapulmonary ____/____ ☐

Cryptococcosis, extrapulmonary ____/____ ☐

Cryptosporidiosis, chronic⁶ intestinal ____/____ ☐

Cytomegalovirus disease (other than liver, spleen, or nodes) ____/____ ☐

Cytomegalovirus retinitis (with loss of vision) ____/____ ☐ ☐

HIV encephalopathy ____/____ ☐

Herpes simplex: chronic⁶ ulcers; or bronchitis, pneumonitis, or esophagitis ____/____ ☐

Histoplasmosis, diss. or extrapulmonary ____/____ ☐

Isosporiasis, chronic⁶ intestinal ____/____ ☐

Kaposi's sarcoma ____/____ ☐ ☐

Lymphoma, Burkitt's (or equivalent) ____/____ ☐

Lymphoma, immunoblastic (or equivalent) ____/____ ☐

Lymphoma, primary in brain ____/____ ☐

Mycobacterium avium complex or M. kansasii, diss. or extrapulmonary ____/____ ☐ ☐

M. tuberculosis, pulmonary ____/____ ☐ ☐

M. tuberculosis, diss. or extrapulmonary ____/____ ☐ ☐

Mycobacterium of other or unidentified species, diss. or extrapulmonary ____/____ ☐ ☐

Pneumocystis carinii pneumonia ____/____ ☐ ☐

Pneumonia, recurrent⁷ ____/____ ☐ ☐

Progressive multifocal leukoencephalopathy ____/____ ☐

Salmonella septicemia, recurrent ____/____ ☐

Toxoplasmosis of brain ____/____ ☐ ☐

Wasting syndrome due to HIV⁸ ____/____ ☐

FOR WOMEN

Yes

No

Unk

Is this patient currently pregnant? ☐ ☐ ☐

Expected delivery date (mm/dd/yyyy) ____/____/____